STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaints IN00145602 and IN00146163. Complaint IN00145602 - Substantiated. A State deficiency related to the allegations are cited at F9999. Complaint IN00146163 - Substantiated. No deficiencies related to the allegations are cited Survey dates: March 25 and 26, 2014 Facility number: 000230 Provider number: 155524 AIM number: 100275000 Survey team: Susan Worsham, RN -TC Census bed type: SNF: 9 SNF/NF: 121 Total: 130 Census payor type: Medicare: 13 Medicaid: 86 Other: 31 Total: 130	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Sample: 04 This state finding is cited in accordance with 410 IAC 16.2. Quality review completed on March 28, 2014; by Kimberly Perigo, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F009999	3.1-13 Administration and management (g) The administrator is responsible for the overall management of the facility, but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibility of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to immediately inform the division of a resident elopement. (Resident#A) Findings include: Report dated 3/7/14 provided by the Chief Executive Officer (CEO) indicated incident details dated	F009999	Please accept our plan of correction allegation of compliance. These statements made in this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. Our date of compliance will be April 10, 2014. On behalf of The Health Care Center of Glenburn Home, and due to the nature of the compliant, we are requesting Paper Compliance for this survey. Submission of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of the requirements under State and Federal Law. F9999 The resident involved in this elopement was immediately placed on 15 minute checks until he was transferred to a secure unit with physician and family concurrence. However, this issue has the potential to affect all residents and the following action occurred. Facility policy and ISDH policy related to unusual occurrences that must be investigated and reported to the ISDH LTC Division have been reviewed by the management team of Glenburn. Staff will receive another in-service on these policies and their role in	04/10/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3/4/14, which described Resident #A was observed outside the building walking on the sidewalk right outside the front door. Resident #A was quickly retrieved and re-directed back into the facility. Resident was assessed and a wanderguard (alarm system device placed on a resident, either on the wrist or ankle, who have been assessed to have exit seeking behaviors. The system sends out an audible (hearing) alarm to alert staff that a resident was close to a door going out of the facility.) One had been placed on Resident #A's right ankle. Family/Admin/DON all notified. Resident#A's wanderguard was changed to ensure functioning. Interview with RN #1 on 3/26/14, at 3:50 p.m., indicated Resident #A had increased exit behavior, so Resident #A was put on 15 minute checks. RN#1 indicated seeing Resident #A in the hallway toward the front door with staff. Approximately 5 minutes later Resident #A was brought back to the nurses station by a staff member, indicating they had found Resident #A right outside the front door. Resident#A indicated he was going to his truck and to go home. Resident #A assessed and no injuries were noted and Resident #A did not state any concern. The wanderguard		communicating any events that possibly count be considered reportable on 4/8 and 4/9, 2014. Unit mangers or their designee will continue to review the 24-hour reports and Incident Reports daily Monday-Friday to ensure timely identification of any unusual occurrences that may require additional investigation and/or reporting to ISDH and other state agencies. Saturday and Sunday, the day shift Charges Nurses will report any events on the 24 hour report that are "unusual occurrences" that potentially should be reported to insure compliance with ISDH rules to the On-Call Nurse. The On-Call Nurse Manager or their designee will be responsible for reporting appropriate "Unusual Occurrences".Unit Managers or On Call Nurse Manager will inform the DON, who will alert the Administrator of the same. This deficiency speaks directly to the failure to report. It should be noted that the DON and Administrator who were responsible at the time of the elopement on 3/04/2014 resigned unexpectedly on 03/05/2014. There is no evidence that links the elopement and the resignations. But, it was in the midst of hiring a new DON and an interim Administrator that the Executive Director learned of the unreported elopement. She had the Assistant DON immediately report. Subsequent to these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on Resident #A's ankle was removed and a new wanderguard attached to Resident #A's ankle. RN #1 Indicated DON was informed and RN #1 was advised to have Resident #A be a 1 on 1 (one staff member to one resident). Interview with Resident #A's daughter on 3/26/14 at 3:15 p.m., (daughter is nurse here at the facility) indicated she was notified Resident #A had gotten out of the building, but was re-directed back and no injuries were noted. Daughter indicated Resident #A was having increased exit seeking behaviors, and they were slowly being acclimated to the secured unit for possible placement at a later date. Daughter indicated alarms can be heard all the way to the back units when the family doors are open. She indicated she knew her father was wearing a wanderguard on (gender) ankle. Date of alleged event was 03/04/14 and was reported to the division on 03/07/14. Interview with CEO on 3/25/14 at 2:24 p.m., indicated the elopement incident was not reported to her or known by her until 3 days later (03/07/2014), when staff came up to		events the Executive Director received a written statement from an employee who responded to the elopement . She stated that she reported the elopement to the DON who told her this was not reportable and to start 15 minute checks. That is where the communication break down seems to have occurred. The new DON and Interim Administrator were in place at the time of this survey. The DON and Administrator will monitor in insure compliance. The alleged date of compliance is 4/10/2014.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155524	A. BUILDING 00 B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CENTER AT GLENBURN HOME	618 W GLENBURN ROAD LINTON, IN 47441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her and asked her about the elopement, which allegedly occurred on 03/04/2014. At that time she indicated she informed ISDH.			